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- Research: Effect of the quality and outcomes framework on diabetes care in the United Kingdom (*BMJ* 2009;338:b1870)
- Research: Effect of social deprivation on blood pressure monitoring and control in England (*BMJ* 2008;337:a2030)
- Research: Self reported receipt of care consistent with 32 quality indicators (*BMJ* 2008;337:a957)
- Research: Impact of financial incentives on clinical autonomy and internal motivation in primary care (*BMJ* 2007;334:1357)

Going local: devolving national pay for performance programmes

The recommendation that part of the Quality and Outcomes Framework be devolved to local areas has not been widely implemented. However, the experience of **Christopher Millett and colleagues** shows that it can help focus attention on local health needs

International evidence underlines the importance of high quality primary care in achieving an effective, efficient, and equitable health system and in improving population health.[1 2] This evidence has led governments in many countries to increase their investment in primary care and introduce initiatives to improve quality, such as greater use of electronic patient records and decision support, clinical audit, greater performance monitoring and, more recently, pay for performance.[3-5]

The UK has embarked on an ambitious quality improvement effort since the late 1990s. An important part of this was the introduction of the world's largest pay for performance programme, the Quality and Outcomes Framework (QOF), which was implemented nationally as part of a new general practitioner contract in April 2004. The framework links 25% of general practice income to achievement on 134 quality indicators and primarily aims to strengthen secondary prevention of common chronic conditions such as diabetes and stroke. Although the framework may have improved and standardised many incentivised aspects of care,[6-8] the quality of primary care in the UK remains variable,[9] and the NHS review *High Quality Care For All*[5] signalled a strong desire by the last government to enhance the programme. The review recommended greater emphasis on prevention in QOF; fewer process (and more outcome) quality indicators; that indicator development be better informed by evidence of clinical effectiveness; and that part of the programme's budget should be devolved to local primary care organisations. The last recommendation has proved controversial and is yet to be widely implemented.

A consultation on the future of the QOF published in 2009 found that views on devolving it to local areas are polarised between NHS management (cautiously supportive) and general practitioners (in opposition).[10] Respondents who were supportive recommended that no more than 5% of the annual QOF budget be made available for local schemes initially. So what are the arguments?

Advantages and disadvantages of local targets

Devolving part of the QOF to local areas could be beneficial for several reasons. Firstly, it would allow primary care organisations to set and reward more ambitious targets than those set nationally. Although achievement of national targets was high in the first year of the contract, recent evidence suggests that quality improvement has stalled since 2005, possibly because there is little financial incentive for practices to improve further.[11] Despite this, general practice negotiators refused a recommendation by the National Institute for Health and Clinical Excellence (NICE) to improve care by raising payment thresholds for a small number of quality indicators from 2010-11.

Secondly, local targets provide opportunities to pilot and improve new quality indicators before they are rolled out nationally. More rigorous evaluation of effects will be feasible through comparative studies using non-intervention sites as controls. This will inform the work of NICE, which has new responsibilities for developing and testing national and local QOF indicators.

Thirdly, local incentives may promote greater investment in and ownership of the quality agenda among clinicians and managers in local health economies. This is important because financial incentives are likely to have most effect when they are consistent with professional values[12] and are delivered as part of an intervention package that includes tailored education and information technology support.[13]

Box 1 | Methods for the development of new quality indicators

- *Step 1*—A long list of 16 local priority areas was identified from local health indicators and performance against key national standards
- *Step 2*—Delphi process with local stakeholder group rating priority areas (using a Likert scale) according to perceived importance locally and feasibility of developing quality indicators for primary care
- *Step 3*—Development of quality indicator set for prioritised areas based on reviews of quality indicator databases, the research literature, policy documents, and publications by the national QOF expert panel
- *Step 4*—Second Delphi process to score (using a Likert scale) proposed quality indicators for soundness, importance, feasibility, and clarity
- *Step 5*—Formal consultation on proposed indicator set with primary care staff and patients during educational meetings, practice visits, email, and web
- *Step 6*—Translation of indicators into a standard format that can be measured using data in primary care
- *Step 7*—Identification of resources to support implementation of indicators in practice including training opportunities and printed materials
- *Step 8*—Publication of indicators with accompanying resources

Box 2 | Prioritised areas in first year of QOF+

Higher thresholds for existing national QOF quality indicators

- Blood pressure, cholesterol, and haemoglobin A_{1c} control for patients with diabetes, hypertension, coronary heart disease, or stroke
- Annual asthma review, care plans for people on mental health registers, cervical screening

New priority areas (clinical)

- Smoking (status ascertainment and cessation advice)—all patients aged >15 years, pregnant women
- Alcohol misuse—screening of patients on several disease registers and brief advice
- Breast feeding—advice and support during antenatal and newborn checks
- Vascular risk assessment—all patients aged 35-74 years
- Tuberculosis screening—new UK entrants from countries with high prevalence
- Disease registers for eczema, psoriasis, rheumatoid arthritis, and osteoarthritis

New priority areas (non-clinical)

- Recording of ethnicity and first language—new registrations and patients on disease registers
- Patient information and experience
- Patient safety

A full list of indicators and a programme description can be found at www.qofplus.org.uk

Fourthly, incentives could be better targeted to reflect local health needs. Finally, local targets might prove an effective mechanism for the delivery of interventions specifically aimed at reducing health inequalities. Previous work suggests that the QOF has not had an effect on many important healthcare inequalities,[14] and the recently published Marmot review recommended that indicator thresholds be increased to improve this.[15]

The potential benefits of local incentive schemes need to be weighed against possible drawbacks. Planned changes to transfer responsibility for commissioning to general practitioner consortiums may produce conflicts of interest.[16] This is because general practitioners will serve as both payers and providers for local financial incentive schemes. Furthermore, many primary care organisations lack the managerial and professional capacity and information technology infrastructure to effectively commission local incentive schemes. This is shown by the fact that existing provisions for local quality improvement schemes in the general practitioner contract (as local enhanced services) have been underused.[17] These schemes differ from the QOF as they typically pay for activity on a per patient basis rather than rewarding improved outcomes at the practice population level and tend to be poorly monitored. Although management capacity to develop local schemes may be further eroded by the abolition of primary care trusts, the formation of general practitioner consortiums means that the scope for clinical engagement in such schemes will increase.

Variations in healthcare may also increase if local schemes are successful in improving the quality of care more rapidly among practices in affluent areas that can reach higher targets more easily. A final danger, as with the national QOF, is the potential for local schemes to have unintended consequences, such as practitioners neglecting areas of care that are not included.

Learning from early adopters

A few primary care organisations have developed local QOFs using existing funding allocations. The largest such programme is QOF+, which was launched in the London borough of Hammersmith and Fulham in September 2008. QOF+ will run for five years with an annual cost of £2.2m (€2.6m; $3.5m), 52% of the local annual spend on the national QOF. The local primary care trust serves 180 000 residents covered by 32 general practices and two main acute hospitals. The population is young (one third aged 20-34 years), mobile (12% turnover a year), and culturally diverse (22% from ethnic minorities) with considerable income inequality. One of the key aims of QOF+ is to improve indicators of poor health in the borough, which include higher rates of smoking related diseases, tuberculosis, and alcohol related hospital admissions and lower breastfeeding rates than elsewhere in the country.[18]

Methods for development of QOF+

QOF+ was developed by a steering group chaired by the primary care trust's medical director and consisting of local practitioners, management, and academics. The group used a mixed methods approach to identify and agree priority areas and quality indicators, including a modified Delphi process originally developed by RAND and recently used by the Organisation for Economic Cooperation and Development's healthcare quality indicator project (box 1).[19] This involved developing a long list of potential priority areas by reviewing information on local health priorities, the effectiveness of interventions in primary care to tackle them, and the primary care organisation's performance against national standards. Quality indicators were selected and refined using Institute of Medicine criteria: relevance, scientific soundness, and feasibility.[19]

Forty eight indicators spanning both clinical and non-clinical domains were introduced in the first year (box 2). As in the national QOF, each indicator has a target performance range and a fixed number of points allocated that are remunerated using a tariff based process. QOF+ provides additional financial incentives for practices achieving higher thresholds for 12 existing indicators in the national QOF. For example, practices currently earn 57 points (£7125 on average) if 70% of their hypertensive patients have blood pressure below 150/90 mm Hg. Under QOF+ practices can earn an additional 29 points (£3625) if 90% of their hypertensive patients attain this treatment target. The remaining 36 indicators incentivise preventive action on local health priorities. Levels of exception reporting (a mechanism which allows practitioners to exclude patients from quality indicators) were tracked in the first year but no explicit caps were set. Priority areas and quality indicators are to be reviewed annually. Practices are supported through a series of dedicated training events and customised information technology tools that provide comparative ranking data, monthly reporting, and patient specific reminders. Performance on quality indicators is regularly reviewed and any areas of concern are discussed during practice visits.

Some early lessons have emerged that should be considered when developing local financial incentive schemes. The financial, technical, and human resource requirements for developing and implementing the programme were considerable. In particular, the primary care trust's lack of clinical and health informatics expertise meant that £150 000 was required to support

indicator development, primary care staff training, and programme monitoring. The costs of developing the programme would have been considerably higher without the input of an academic partner (Imperial College London), which provided expertise and capability at a modest cost. A bespoke information technology system was required as none of the current systems were suitable for the scheme.

Dedicated training sessions were essential to overcome well documented concerns among healthcare professionals about incorporating primary prevention interventions, such as alcohol screening, into clinical practice.[20] We also found that rates of exception reporting increased substantially for many national QOF indicators that were assigned higher payment thresholds in QOF+. For example, the percentage of diabetes patients excepted from the HbA1c control indicator (QOF+ requires 77% of patients below 7.5% for maximum payment) increased from 9.7% to 15.6%; the national rate is 9.2%.

Conclusions

Our experience suggests that current reluctance to set up local incentive schemes may result in missed opportunities to improve quality, encourage innovative service development, and tackle local health priorities. However, the resource requirements for such schemes are considerable and their widespread adoption is unlikely without the government devolving part of the QOF budget to primary care organisations for local priorities, expediting plans to develop a national menu of quality indicators for local use, and having an information technology infrastructure that ensures robust monitoring.

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Accepted: 5 October 2010

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Funding: QOF+ is funded by NHS Hammersmith and Fulham. The Department of Primary Care & Public Health at Imperial College London received funds from NHS Hammersmith and Fulham to help develop the QOF+ scheme. We are also grateful for support from the NIHR Biomedical Research Centre scheme, the NIHR Collaboration for Leadership in Applied Health Research & Care scheme and the Imperial Centre for Patient Safety and Quality.

Competing interests: All authors have completed the unified competing interest form at www.icmje.org/coi_disclosure.pdf (available on request from the corresponding author) and declare no support from any organisation for the submitted work; CM and AM have received funding to evaluate the impact of the national QOF scheme on healthcare inequalities; JC led and CH, CM, and AM supported the development of QOF+.

Provenance and peer review: Not commissioned; externally peer reviewed.

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Cite this as: *BMJ* 2011;342:c7085

doc 2 doc

Should cyclists have to wear helmets?

Members of doc2doc, the BMJ Group's online community, are debating this question

yoram chaiter: Yes. I have seen enough head injuries without helmets.

Odysseus: As a race, we face being smothered in legalism which is affecting how children play and how we conduct our daily lives. Long before we all die of natural disasters, we will be unable to turn on the toaster without a legal manual. So bring on the bike helmet to make the world a little less scary and more medically perfect. In my generation I jumped off the shed roof with umbrellas and rode a bike and a billy cart with neither seat belt nor helmet.

Tom Koch: A long time cyclist until arthritis made it problematic, I saw the introduction of helmets in North America and saw the advantage, time after time.

skyesteve: Cycle helmets save lives and reduce the risk of serious injury. So do seatbelts. If one is compulsory it makes no sense that the other is not.

Jon Peterson: No, from a simple principle of liberty. However, the risk of a mode of transport depends greatly on whether you measure accidents per person mile or accidents per hour of travelling. People seem reluctant to factor cost into the equation, although balancing risk of accident against financial cost is just as sensible as balancing it against saving the planet or getting fit or feeling the wind in your hair or whatever. Requiring a cyclist to wear a reflective yellow jacket would both save more lives, and be justifiable—since doing so reduces the likelihood of me driving into them through no fault of my own.

pward: The arguments against encouraging or forcing cyclists to wear helmets are not, in general, libertarian ones. I ask we stay away from emotion and anecdote and instead debate the moral and evidential field.

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